Maine Department of Health and Human Services (DHHS) & Guidehouse

Rate Reform Studies of Long-Term Care Services Under MaineCare

Rates Workgroup Meeting #2

April 12, 2023

Agenda

- Workgroup Meeting Schedule: 5 Minutes
- Review of Input From Meeting # 1: 15 Minutes
- Group Discussion Questions: 35 Minutes
- Closing: 5 Minutes

Workgroup Meeting Schedule

Proposed Meeting Topics	Topic	Format	Timeframe	Notes and Considerations
Meeting #1 Introductions and Overview	• Introduction • Rate discussion • Rate/APM questions	Zoom	March 13, 2023	☑
Meeting #2 Data Methodologies and Rate Study	Direct/Indirect & Capital costs	Zoom	April 12, 2023	**Today**
Meeting #3 Presentation of Risk Adjustment Options	Risk Adjustment Discussion	Zoom	April 26, 2023	
Meeting #4 Presentation of Risk Adjustment Options	Trend Discussion	Zoom	May 17, 2023	
Meeting #5 Presentation of Options for VBP and Quality	VBP and Quality	Zoom	May 30, 2023	

Review of Input From Meeting # 1

We received valuable input at our first meeting on the cost components of a rate build-up. Here is a sample of your feedback:

- Capital Cost
  - The capital cost component should be redesigned to allow pass-through reimbursement for uncontrollable and statutory expenses such as taxes, benefits, electricity, and gas/propane.
  - Facilities are old and in need of updates. The current system does not support this, and it is important to sustain access to capital and allow for re-investment in upgrades and replacements.
  - Capital reimbursement is currently retrospective.
  - Banks have stopped lending to facilities due to negative net operating income (NOI) and failing debt-service coverage ratio (DSCR) covenants so there is almost no additional access to capital at this point.
- Operating Cost (Direct/Indirect)
  - Direct care rates are not sufficient to cover current demands of direct care workers and contract rates. It is hard to stay under the current cap with employee wages and agency staffing expenses all increasing rapidly.
  - Providers are currently disincentivized to operate below medians.
  - Lots of new federal regulations impose costs for new systems, labor hours, etc., but there is currently no additional payment to cover these costs until the next rebasing.

Review of Input From Meeting # 1 (Cont.)

We received valuable input at our first meeting on the cost components of a rate build-up. Here is a sample of your feedback:

- Adjustments
  - Providers are concerned with how caps are applied and how they may be calculated under a new system.
  - Rate increases are not always realized because adjustment factors may negate the increases.
  - Rates should consider regional cost differences. Urban vs. rural and geographic rates should be reviewed specific to staffing costs in rural areas which are on the rise along with local worker shortage.
- Trend/Inflation %
  - Utility costs are rising and currently are increasing faster than inflation.
  - Trend/Inflation is currently too low. Trend is not timely to increases in operating costs. Inflation adjustments are too low and lag with reality.
  - Focus on Northeast and Maine data more so than national data to reflect the local market.

Review of Input From Meeting # 1 (Cont.)

We received valuable input at our first meeting on the cost components of a rate build-up. Here is a sample of your feedback:

- Risk Adjustment
  - Reimbursement for dementia and behavioral needs is inadequately addressed in current direct care payment.
  - Rates of pay do not align with the complexity of the work they do.
- Total Rates, Approach, Program Future, and Other
  - A novel approach should not add major complexity to the facilities.
  - Peer groups need re-alignment from the current methodology.
  - Providers are interested in the frequency of rebasing and ideas of how the initial rates will be evaluated in future to ensure the goals are met on a long-term basis.
  - There currently is no bad debt allowance and no profit factor in the rates. Providers are only getting a percentage of what Medicaid deems allowable. They also have trouble collecting patient responsibility and don't get 1-3% of it.
  - Rates are insufficient to cover allowable costs of providing care for some facilities. There is no current program that ensures rates quickly fund operating shortfalls. We resort to working through legislature because there is no better avenue.

Group Discussion Etiquette

DHHS asks that work group members limit sharing information from work group meetings outside of the group

Raise Hand

Use the raise hand feature to hold your place in “line” to speak in activities where there is a lot of discussion

Mute

Use the mute feature to avoid echoes and background noise when you are not speaking

Video

Keep your camera on during the discussion

Chat Box

Use the chat box feature to send messages to the group for all to see

SESSION EXPECTATIONS

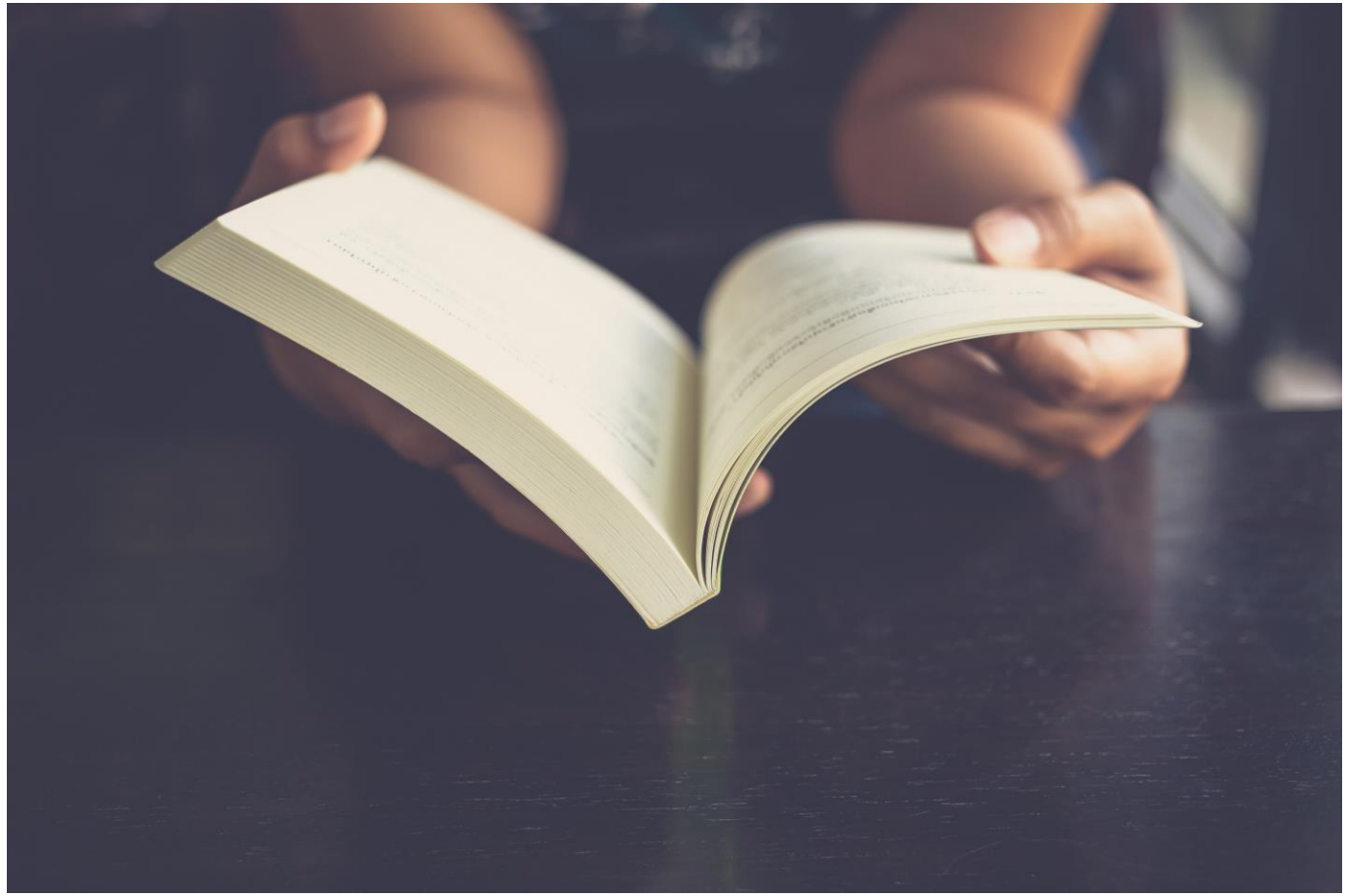
- **Participation** is the ultimate key to a successful discussion today
- **Respect** each other’s ideas and opinions
- **Add** items to parking lot that might take over the flow.
- Make the most of the time you have **together**
- Don’t **focus** on wordsmithing. We’ll perfect and validate language following the discussion

Direct, Routine, Fixed, and Personal Care Services

- Direct Costs NF/RCF are costs that are directly identifiable with a specific activity, service or product of the program. For example:
  - Salaries and wages, fringe benefits, contractual labor costs, training, vacation, sick leave and other paid time off, cost of educational activities, medical supplies, resident assessments, etc.
- Routine Costs (Indirect) NF/RCF include items for provision of routine services. Routine services mean the regular room, dietary services, and equipment and facilities. For Example:
  - Fiscal services, administration functions costs, plant operation, utilities, laundry, housekeeping, dietary, clerical, office supplies, transportation, etc.
- Fixed Costs (Capital) NF are costs that are directly identifiable with a specific activity, service or product of the program. For example:
  - Depreciation on building and equipment and motor vehicles, depreciation on land and improvements, real estate and property tax and insurance, interest, rental expense, water and sewer fees, etc.
- Personal Care Services (PCS) RCF are costs for activities of daily living, household tasks, and medication reminders. For example:
  - Mobility, transfers, dressing, eating, shopping, laundry, cleaning, medication reminders, etc.

Open Discussion:
Alternate Payment Methodologies

35 minutes



As we consider updated rate methodologies:

1. Indirect and routine costs for NFs are capped at the lessor of actual costs of the provider or of the statewide 110% median. What changes would you make to this methodology?
2. What suggestions would you make to deal with unexpected high-cost trends, e.g., wages?
3. MaineCare is considering setting some or all rate components on a **prospective rather than retrospective** basis. What should they take into consideration with such a move?
4. What data or other facility characteristics should MaineCare consider when looking to redefine peer groups?

As we consider updated rate methodologies:

1. Indirect and routine costs for NFs are capped at the lessor of actual costs of the provider or of the statewide 110% median. Capital is a pass through, what changes would you make to this methodology? *please provide your comments in the chat box*

8.75 minutes

1

Increase the 110% to 130+%

2

110% of the median needs to be raised to 130%.

3

Make it a prospective rate. No cost settlement for actual costs being less than the prospective rate (similar to other payors).

4

Rates should be transparent- no surprise adjustments. Rates need to be sufficient to cover all allowable costs.

5

Adjust statewide NF caps at a level that captures costs for all but outlier facilities. Based on analysis of 2022 rebasing, 130% of median would have better met that need.

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6

Capital - consider a fair value payment. Eliminate pre approvals for re-financing.

7

Rates should be reflective of changes in regulations, cost of operations, census, acuity, etc.

8

Continue with a transparent and frequent rebasing cycle.

9

Other State systems provide a small incentive to provider whop operate below a percentage median. This would encourage and promote effiency.

10

NF regional wage adjustments now only consider 50% of the relative difference in costs between regions. That limits facilities operating in areas of more extreme worker shortages at a disadvantage. I recommend adjusting so wage adjustment is considered at 100%.

11

Northern Region facilities should be given extra for increased heating and snow removal costs.

12

Hello We as an industry have done financial analysis to see the impact and we would like this information included in the summary using 130% vs. 110%. costs which can be 1 to 2 years old and outdated in this ever and fast changing environment. thank you

13

(12 con't) It is a fair representation of our industry. We need to be transparent and not look to back into this calculation by having it only state driven data. Also there needs to be some system to capture "current" operating costs and not just historical

14

A lot of valuable time is wasted on retrospective audits, both by facilities and Medicaid Audit.

15

Funding needs to support reasonable and necessary costs plus a margin to allow providers access to capital and ability to reinvest in building and equipment updates. Rates for Mainecare (now 70% of our business) needs to be enough to keep private investors willing to be in this business.

16

in addition, still waiting for 2020 settlements, impacting cash flow for multiple years

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As we consider updated rate methodologies:

2. What suggestions would you make to deal with unexpected high-cost trends, e.g., wages?
   *please provide your comments in the chat box

8.75 minutes

1
***Verbal Discussion*:** Not seeing a decrease in contract vs perm staff. Staff not coming back into the industry. Former perm staff coming back at contract staff because of higher wages.

2
Health insurance costs increasing 15+% annually

3
Additional "Extraordinary Circumstances" funding should be provided on an industry wide basis. For example, everyone's health insurance premiums jumped 30% last year due to the cost of Covid to insurers. The entire industry should have received an increase for this.

4
I don't think wages are going to go backwards. If we are going to protect access to NF and res care facilities, adequate funding needs to be provided. A significant investment is going to be needed going forward

5
. *(4 con't.)* I think the dozens of facility closures even pre-COVID indicates that the current system doesn't cover costs and isn't nimble.

6
ditto from other types of insurance - property, cyber liability

7
Wages AND benefits are critical to solving work force crisis. Health insurance should be a fixed cost. Shopping around for a better deal is a misnomer and insulting to providers who are struggling to offer decent health insurance.

8
Labor costs will stay high so long as the root issue of too few workers in Maine is unsolved. Temp agencies are a large part of the problem as they hire away our staff and resell to us at inflated rates.

9
Cannot find perm folks, forced to use agency, cannot afford to operate long term with this staffing issue

10
***Verbal Discussion*:** : take age demographics into account, not a lot of young people to fill the workforce due to Maine having an older population makeup.

11
***Verbal Discussion*:** 6,000 RNs retired during COVID, not enough staff to backup fill. Pressure for nursing agency increasing. No sustainable for the long term with this shift.

12
I suggest you read interesting labor data from slide deck of presentation Michelle Probert made to HHS Committee.

13
We are seeing no significant change in a decrease in nursing agency and a new industry has been created to get a higher wage and we do not see this going back.

14
The labor shortage is a national issue. Maine needs to ask D.C. to entice immigrants to work in LTC. Provide faster citizenship for those that go work in long term care.

15
Critical Access Nursing Home waivers should be implemented to preserve Rural Health efforts and provide stability and assurances to those markets with scarce resources. All other markets should start reimbursement at adjusted cost 100% and then add-ons

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(15 con't) for other specialty frailty factors and quality measure scores. Zero funding the LTC COP has led to imbalance in our workload, staff taking on dual/triple roles and has caused roadblocks and barriers to retention and attempts to rebuild this vocation.

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As we consider updated rate methodologies:

3. MaineCare is considering setting some or all rate components on a prospective rather than retrospective basis. What should they take into consideration with such a move?
   **please provide your comments in the chat box*

8.75 minutes

1

Frequent and timely rebasing is needed within any system.

2

Retrospective adds burden but if a cost is Cost Reimbursed, there has to be a way to submit requests reimbursement for any that were underfunded. A fair rental system would alleviate this problem
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3

Agree with Tammy B. on frequent/timely rebasing. The State used to provide "quarterly" rate letters.

4

We may be supportive of this but it MUST BE A PHASE IN PROCESS and not all at once. These financial stress and cash flow conversion could be extremely harmful to our industry.

5

(4 con't) To make this conversion work the industry needs SHADOW rates in advance and a new base line of the rebase start for funding. No surprises. thank you

6

age of facilities and capital investment required for safety and efficiencies and to address

7

Agree 100% with Glen C. on "phasing in."

8

Agree with Glen. Many facilities are fragile.

9 Regarding a prospective payment system. Bear in mind that Mainecare pays for 70% of NF residents and more in RCF setting. Getting it wrong will have immediate consequences. Providers will not be able to make up shortfalls by profits off other payers.

10

Thank you Peter for acknowledging that. We want to have an efficient process and there are lots of good ideas to share!

11

Prospective approach I would worry about frequency and criteria, it would be valuable if higher needs residents coming in gave immediate change...down side is always a reduction

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As we consider updated rate methodologies:

4. What data or other facility characteristics should MaineCare consider when looking to redefine peer groups? *please provide your comments in the chat box*

8.75 minutes

1 One factor should continue to be facility size due to licensing and efficiency variables.	2 Consider a climate related peer group based on heating and cooling degree days for utilities and snow removal expenses.	3 Rural location should in some way be considered to assure access thru out the State of Maine. Much of Maine's rural locations have very low median income and much if not all the facility resident are	4 *(con't 3)* MaineCare --- with no possible way to generate a bottom line -- unless there is an opportunity for a margin.	5 There are market driven labor rate differentials to consider across the state.	6
7	8	9	10	11	12
13	14	15	16 .	17	18

PARKING LOT

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Questions or Comments?

Please send any questions or additional feedback from today's discussion to Bryan Lumbra (Bryan.K.Lumbra@maine.gov) and Justyn Rutter (justyn.rutter@guidehouse.com).

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